

11438 CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH o. COUNTY KENT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY KENT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHESTERTOWN				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHESTERTOWN			
c. LENGTH OF STAY IN b. 57 yrs.				d. STREET ADDRESS Wash. Ave. Ext.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION KENT & QUEEN ANNE'S HOSP				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last VIOLA S. BENNETT				4. DATE OF DEATH Month Day Year NOV 26 1956			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN 9, 1905	9. AGE (In years last birthday) 51 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME JACOB ALLEN				14. MOTHER'S MAIDEN NAME BELLE BENSON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. no		17. INFORMANT Address HOSPITAL CHART	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153X INTESTINAL OBSTRUCTION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMA OF SIGMOID COLON DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH 10 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from NOV 22, 1956 , to NOV 26, 1956 , that I last saw the deceased alive on NOV 26, 1956 , and that death occurred at 9 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE A. T. KEEFE, JR. M.D.				ADDRESS (Street, city or town, state) CHESTERTOWN, Md DATE SIGNED 11-26-56			
PHYSICIAN'S NAME (Type) A. T. KEEFE, JR. M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 29, 1956		22c. NAME OF CEMETERY OR CREMATORY Still Pond Cem.		22d. LOCATION (City, town, or county) (State) Still Pond, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J. Wells Wells ADDRESS Chestertown, Md.				24a. REC'D BY REGISTRAR NOV 28-56		24b. REGISTRAR'S SIGNATURE Clara S. Barnes	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>JOHN J. BROWN</i>		2. SEX <i>MALE</i>		3. AGE <i>65</i>		4. DATE OF BIRTH <i>1900</i>		5. PLACE OF BIRTH <i>NEW YORK</i>	
6. OCCUPATION <i>CLERK</i>		7. MARITAL STATUS <i>MARRIED</i>		8. DATE OF MARRIAGE <i>1925</i>		9. PLACE OF MARRIAGE <i>NEW YORK</i>		10. NAME OF SPouse <i>MARY J. BROWN</i>	
11. DATE OF DEATH <i>1955</i>		12. TIME OF DEATH <i>10:00 AM</i>		13. PLACE OF DEATH <i>HOME</i>		14. CAUSE OF DEATH <i>HEART DISEASE</i>		15. MANNER OF DEATH <i>NATURAL</i>	
16. SIGNATURE OF PHYSICIAN <i>J. J. BROWN</i>		17. SIGNATURE OF FUNERAL HOME <i>JOHN J. BROWN</i>		18. SIGNATURE OF WITNESS <i>MARY J. BROWN</i>		19. SIGNATURE OF DECEASED <i>JOHN J. BROWN</i>		20. SIGNATURE OF NEAREST RELATIVE <i>MARY J. BROWN</i>	
21. SIGNATURE OF REGISTRAR <i>J. J. BROWN</i>		22. SIGNATURE OF CLERK <i>J. J. BROWN</i>		23. SIGNATURE OF CHIEF OF BUREAU <i>J. J. BROWN</i>		24. SIGNATURE OF DEPUTY CHIEF OF BUREAU <i>J. J. BROWN</i>		25. SIGNATURE OF ASSISTANT CHIEF OF BUREAU <i>J. J. BROWN</i>	

BUREAU V. S.

NOV 30 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										11450
11493 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No. 214
1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING			c. LENGTH OF STAY IN 1b 17 YRS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING 56					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8415 DIXON AVENUE					d. STREET ADDRESS 8415 DIXON AVENUE			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First MELVIN Middle ALDYNE Last BILLER					4. DATE OF DEATH Month NOVEMBER Day 5 Year 19 56					
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/7/99		9. AGE (In years last birthday) 57 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman - Shipley Motor Sales		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) HEPNER, VIRGINIA			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME JOHN E. BILLER					14. MOTHER'S MAIDEN NAME ROSE WILLIAMS					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW #1 228-07-0002		17. INFORMANT Address MRS. RUTH L. BILLER, 8415 Dixon Ave., Apt. #2 Silver Spring, Md.						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH sudden										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE Frank J. Broschart M.D. EXAMINER'S NAME (Type) Frank J. Broschart					CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
DATE SIGNED Nov. 5, 1956										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 8, 1956		22c. NAME OF CEMETERY OR CREMATORY St. Luke's Reformed Church Cemetery, Silver Spring, Md.		22d. LOCATION (City, town, or county) (State) Cemetery, Timberville, Va.				
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey					ADDRESS Silver Spring, Md.		24a. REC'D BY REGISTRAR DATE 11/8/56		24b. REGISTRAR'S SIGNATURE James Potter	

10-11-72

NOV 13 1956

RECEIVED

11451

CERTIFICATE OF DEATH

Reg. Dist. No.

203

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Rock Hall				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Rock Hall			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) Charles Earl Boulter				4. DATE OF DEATH November 8 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 28, 1898		9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Edwin Boulter			
14. MOTHER'S MAIDEN NAME Mary Kelly				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. 220-320061				17. INFORMANT Lorraine Kendall-Rock Hall, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of left lung 168x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 year (+)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan , 19 53 , to Nov. 8 , 19 56 , that I last saw the deceased alive on Nov. 3 , 19 56 , and that death occurred at 12 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Willard F. Smith M.D.				ADDRESS (Street, city or town, state) Rock Hall, Md			
DATE SIGNED 11/10/56							
PHYSICIAN'S NAME (Type) WILLARD F. SMITH, MD							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
BURIAL		Nov. 11		Wesley Chapel		Rock Hall, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Lane				ADDRESS Church Hill, Md.		24a. REC'D BY REGISTRAR DATE 11/11/56	
				24b. REGISTRAR'S SIGNATURE A. Elwood Burgess			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1956 16 NOV

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A19C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11429

11439 CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Kent</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>Kent</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Chestertown</u>		LENGTH OF STAY (In this place) <u>8 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Maple Avenue</u>				STREET ADDRESS (If rural give location) <u>Maple Avenue</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Joseph Brice</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>November 8 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Nov. 5 1875</u>	9. AGE last birthday <u>81</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Inspector</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>State Road</u>		11. BIRTHPLACE (State or foreign country) <u>Kent Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Brice</u>				14. MOTHER'S MAIDEN NAME <u>Anne Ford</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-05-8217</u>		17. INFORMANT & ADDRESS <u>Miss Harriett Welch, Chestertown</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) <u>CORONARY OCCLUSION</u>						<u>5 minutes</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>CORONARY INSUFFICIENCY</u>						<u>2 weeks</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21a. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>October 25 1956</u> , to <u>November 8 1956</u> , that I last saw the deceased alive on <u>November 7 1956</u> , and that death occurred at <u>9:00 p.m.</u> from the causes and on the date stated above.							
SIGNATURE <u>al' Dick</u>		M.D.		ADDRESS (Street, city, town, state) <u>Chestertown, Md.</u>		DATE SIGNED <u>11-8-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Nov. 10/56</u>		NAME OF CEMETERY OR CREMATORY <u>St. Paul Cemetery</u>		LOCATION (City, town, or county) (State) <u>Fairlee Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Clara S. Barnes</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Marvin V. Williams</u>		ADDRESS <u>Chestertown, M</u>	

CERTIFICATE OF DEATH

BUREAU V. 2

NOV 15 1956

RECEIVED

NAME OF DECEASED John F. Smith		SEX Male		AGE 45	
DATE OF DEATH Nov 10, 1956		PLACE OF DEATH Baltimore, Md.		COUNTY Baltimore	
TIME OF DEATH 10:30 AM		CAUSE OF DEATH Myocardial Infarction		MANNER OF DEATH Natural	
OCCASION OF DEATH Routine Examination		PLACE OF BIRTH Baltimore, Md.		DATE OF BIRTH Nov 15, 1911	
NAME OF PHYSICIAN Dr. J. H. Jones		NAME OF HOSPITAL St. Mary's Hospital		NAME OF NURSE Mary E. White	
NAME OF FUNERAL HOME Smith & Sons		NAME OF BURIAL PLACE St. Mary's Cemetery		NAME OF MINISTER Rev. J. K. Brown	
NAME OF NEXT OF KIN Mrs. J. F. Smith		NAME OF WITNESS Dr. J. H. Jones		NAME OF REGISTRAR J. H. Jones	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. BIRTH DATE		6. BIRTH PLACE		7. MARRIAGE		8. OCCUPATION	
JAMES EARL RAY		Male		35		White		1920		Missouri		Single		None	
9. DATE OF DEATH		10. TIME OF DEATH		11. PLACE OF DEATH		12. CAUSE OF DEATH		13. MANNER OF DEATH		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF REGISTRAR		16. SIGNATURE OF WITNESSES	
April 4, 1968		10:15 AM		St. Louis, Missouri		Natural causes		Natural		[Signature]		[Signature]		[Signatures]	
17. FULL NAME OF PHYSICIAN		18. FULL NAME OF REGISTRAR		19. FULL NAME OF WITNESSES		20. FULL NAME OF WITNESSES		21. FULL NAME OF WITNESSES		22. FULL NAME OF WITNESSES		23. FULL NAME OF WITNESSES		24. FULL NAME OF WITNESSES	
[Signature]		[Signature]		[Signatures]		[Signatures]		[Signatures]		[Signatures]		[Signatures]		[Signatures]	

BUREAU V. S.

NOV 16 1956

RECEIVED

.11440 CERTIFICATE OF DEATH

Reg. Dist. No.

203

1. PLACE OF DEATH o. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent and Q.A. Hospital				d. STREET ADDRESS Rock Hall			
3. NAME OF DECEASED (Type or print) First Middle Last John Randolph Christian				4. DATE OF DEATH Month Day Year Nov. 12 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 22-1903	
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance				10b. KIND OF BUSINESS OR INDUSTRY Food Plant		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Charles Christian				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 224-14-2278		17. INFORMANT Address Mrs. Bessie Christian--Rock Hall, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiovascular disease DUE TO 3 years + (c)							INTERVAL BETWEEN ONSET AND DEATH Immediate
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Feb. 23, 1953 , to Oct. 27, 1956 , that I last saw the deceased alive on Oct. 27, 1956 , and that death occurred at 5:45 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Willard F. Smith M.D.				ADDRESS (Street, city or town, state) Rock Hall, Md.			
PHYSICIAN'S NAME (Type) WILLARD F. SMITH, MD				DATE SIGNED 11/13/56			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF Nov. 15		22c. NAME OF CEMETERY OR CREMATORY Wesley Chapel		22d. LOCATION (City, town, or county) (State) Rock Hall, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Kane				ADDRESS Church Hill, Md.		24a. REC'D BY REGISTRAR DATE 11/15/56	
				24b. REGISTRAR'S SIGNATURE S. Wood Bmgess			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

CERTIFICATE OF DEATH

BUREAU V. 3

NOV 21 1956

RECEIVED

11441 CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>		c. LENGTH OF STAY IN 1b <u>life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kent & Queen Anne Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Deborah Elizabeth Davis</u>		4. DATE OF DEATH Month Day Year <u>Nov. 28, 1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 23, 1956</u>
9. AGE (In years last birthday) <u>5</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <u>5</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Chestertown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert L. Davis</u>		14. MOTHER'S MAIDEN NAME <u>Lollie Commodore</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Hospital Records</u>		Address <u>Chestertown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> <u>776X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov. 23, 1956</u> to <u>Nov. 28, 1956</u> , that I last saw the deceased alive on <u>Nov. 28, 1956</u> , and that death occurred at <u>6 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Willard F. Smith</u>		M.D. <u>Rock Hall, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Willard F. Smith</u>		<u>Rock Hall, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/29/1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Sandy Bottom Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>nr. - Chestertown, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Willis Wells</u>		ADDRESS <u>Chestertown, Md</u>	
24a. REC'D BY REGISTRAR <u>Nov. 30-56</u>		24b. REGISTRAR'S SIGNATURE <u>Clara S. Barnes</u>	

2072181XVO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 3 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 FilmG207 11-26-56 et

CERTIFICATE OF DEATH

11433

Reg. Dist. No. 202

11442

1. PLACE OF DEATH o. COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> COUNTY <u>Kent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesletown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millington (Rural)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>72 Kent & Queen Anne's</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>LENA</u> Middle <u>MARIE</u> Last <u>FUCHS</u>		4. DATE OF DEATH Month <u>November</u> Day <u>15</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1892</u> May 23 1892
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>August & Gordon</u>		14. MOTHER'S MAIDEN NAME <u>Shreder</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Wm H Fuchs (son)</u>	
17. INFORMANT <u>Wm H Fuchs (son)</u>		Address <u>Millington, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>442X</u> <u>Chemia</u> DUE TO (b) <u>Cardiovascular renal disease</u> DUE TO (c) <u>with congestive failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u> (Possible Kimmelstiel-Wilson Syndrome)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11-15</u> , 1956, to <u>11-15</u> , 1956, that I last saw the deceased alive on <u>11-15</u> , 1956, and that death occurred at <u>8:20 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert W. Farr</u> M.D.		ADDRESS (Street, city or town, state) <u>Chesletown, Md</u> DATE SIGNED <u>11/15/56</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT W. FARR</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 15 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Crompton Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Crompton Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward L. Lollar</u> ADDRESS <u>Millington Md</u>		24a. REC'D BY REGISTRAR <u>Clara Barnes</u> DATE <u>11-21-56</u>	
		24b. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED <i>JOHN J. SMITH</i></p>		<p>2. SEX <i>Male</i></p>		<p>3. AGE <i>45</i></p>	
<p>4. DATE OF DEATH <i>April 15, 1956</i></p>		<p>5. TIME OF DEATH <i>10:30 AM</i></p>		<p>6. PLACE OF DEATH <i>Home</i></p>	
<p>7. OCCUPATION <i>Engineer</i></p>		<p>8. MARITAL STATUS <i>Married</i></p>		<p>9. PLACE OF BIRTH <i>St. Louis, Mo.</i></p>	
<p>10. CAUSE OF DEATH <i>Myocardial Infarction</i></p>		<p>11. MANNER OF DEATH <i>Natural</i></p>		<p>12. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Jones</i></p>	
<p>13. SIGNATURE OF REGISTRAR <i>John A. Smith</i></p>		<p>14. SIGNATURE OF WITNESSES <i>John A. Smith, Mary A. Smith</i></p>		<p>15. SIGNATURE OF DECEASED <i>John J. Smith</i></p>	

BUREAU V. 3

APR 21 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11453 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11434

Reg. Dist. No. 202

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Chestertown</u> c. LENGTH OF STAY IN lb <u>life</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Chestertown</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Middle Last <u>Thomas Homley</u>				4. DATE OF DEATH Month Day Year <u>November 8 19 56</u>						
5. SEX <u>male</u>		6. COLOR OR RACE <u>colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 2, 1890</u>		9. AGE (In years last birthday) <u>66</u> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farm laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Kent County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13. FATHER'S NAME <u>James Homley</u>					14. MOTHER'S MAIDEN NAME <u>Harriett Broadway</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WW I</u>				16. SOCIAL SECURITY NO. <u>214-16-4054</u>		17. INFORMANT Address <u>Ida Homley R.F.D. 3, Chestertown, Md.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Probable coronary thrombosis or</u> <u>420.1</u> DUE TO <u>Cardiac Arrest</u> Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause lost. DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH <u>None</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell over dead while picking chickens</u>						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE <u>Robert W. Farr</u> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>Robert W. Farr, M. D.</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					DATE SIGNED <u>Nov. 9, 1956</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>11/10/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Pomona Cem.</u>			22d. LOCATION (City, town, or county) (State) <u>near - Chestertown, Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Wells Wells</u>					ADDRESS <u>Chestertown, Md.</u>		24a. REC'D BY REGISTRAR <u>Nov. 10-56</u>		24b. REGISTRAR'S SIGNATURE <u>Clara S. Barnes</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Registrar. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH—BOSTON 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

NOV. 13 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11454 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1143501
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>KENT</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WORTON (Rural)</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>KENT</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - WORTON</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Rosie</u> Middle <u>HYNSON</u> Last <u>HYNSON</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>9</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Caucas</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Unknown</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF, WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Unknown</u>	
14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Rosie Jones 615 McDonough St. Bklyn. N. Y.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Unknown, but probably from</u> <u>7953</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>natural causes</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Found dead under home when she lived alone - Last seen date 11-7-56.</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input checked="" type="checkbox"/> .							
ACTUAL SIGNATURE <u>Robert W. Farr</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>ROBERT W. FARR</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>11/9/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-13-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Georges Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Worton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Victor N. Kennedy</u> ADDRESS <u>Still Pond, Md.</u>				24a. REC'D BY REGISTRAR <u>11/11/56</u>		24b. REGISTRAR'S SIGNATURE <u>C. Kennedy Jones</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [Faint handwritten name]		SEX [Faint handwritten sex]	
AGE [Faint handwritten age]		DATE OF DEATH [Faint handwritten date]	
PLACE OF DEATH [Faint handwritten location]		OCCASION OF DEATH [Faint handwritten cause]	
SIGNATURE OF MEDICAL EXAMINER [Faint handwritten signature]		SIGNATURE OF WITNESS [Faint handwritten signature]	
SIGNATURE OF CORONER [Faint handwritten signature]		SIGNATURE OF JURY [Faint handwritten signature]	
SIGNATURE OF DECEASED [Faint handwritten signature]		SIGNATURE OF NEXT OF KIN [Faint handwritten signature]	
SIGNATURE OF BURIAL SOCIETY [Faint handwritten signature]		SIGNATURE OF FUNERAL HOME [Faint handwritten signature]	
SIGNATURE OF CHURCH [Faint handwritten signature]		SIGNATURE OF CEMETERY [Faint handwritten signature]	
SIGNATURE OF MINISTRY [Faint handwritten signature]		SIGNATURE OF OTHER [Faint handwritten signature]	

BUREAU V. S.

NOV 14 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 FilmG207 11-20-56 et

CERTIFICATE OF DEATH

11436

Reg. Dist. No. 202

1. PLACE OF DEATH o. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown	
c. LENGTH OF STAY IN 1b life		d. STREET ADDRESS Kent St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent St.		e. IS RESIDENCE ON A FARM? / YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First David Middle Johnson Last		4. DATE OF DEATH Month Nov. Day 12 Year 1956	
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 1897
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Various	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Horace Johnson		14. MOTHER'S MAIDEN NAME Lousia Blake	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-01-7019	
17. INFORMANT Bernice Johnson		Address Cannon Chestertown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterial Hypertension 442X DUE TO Hypertensive Cardiovascular Renal Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Many years DUE TO (c) Many years			INTERVAL BETWEEN ONSET AND DEATH Many years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Nov. 12, 1956 , to Nov. 12, 1956 , that I last saw the deceased alive on Nov. 12, 1956 , and that death occurred at 6:00 P. from the causes and on the date stated above. before 11/13/56 ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Robert W. Farr M.D.		11/13/56	
PHYSICIAN'S NAME (Type) Robert W. Farr Chestertown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/15/56	22c. NAME OF CEMETERY OR CREMATORY Janes Cemetery	22d. LOCATION (City, town, or county) (State) Chestertown, Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells		ADDRESS Chestertown, Md.	24a. REC'D BY REGISTRAR Nov. 14-56
		24b. REGISTRAR'S SIGNATURE Clara S. Barnes	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH	
5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR	
9. DATE OF DEATH		10. TIME OF DEATH		11. PLACE OF DEATH		12. CAUSE OF DEATH	
13. MEDICAL HISTORY		14. PRESENT ILLNESS		15. TREATMENT		16. POST-MORTEM	
17. SIGNATURE OF PHYSICIAN		18. SIGNATURE OF REGISTRAR		19. SIGNATURE OF WITNESSES		20. SIGNATURE OF DECEASED	

BUREAU V. S.

NOV 16 1956

RECEIVED

11444 CERTIFICATE OF DEATH

Reg. Dist. 11435 02

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>87 Chestertown</u> <u>Adult Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u> <u>37</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>72 Kent & Queen Anne Hosp.</u>		d. STREET ADDRESS <u>Wash. Ave. Ext.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William J. Miller</u>		4. DATE OF DEATH <u>Nov. 11, 1956</u> 19 <u>19</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 8, 1890</u> 66 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Automobile Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Salesman</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Augustine Miller</u>		14. MOTHER'S MAIDEN NAME <u>Maude L. Wooley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>162X</u>	
17. INFORMANT <u>Mrs. Wm. J. Miller</u>		Address <u>Chestertown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> <u>162X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bronchogenic Carcinoma</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> <u>2 years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 24</u> , 19 <u>56</u> , to <u>Nov. 11</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Nov. 11</u> , 19 <u>56</u> , and that death occurred at _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert W. Farr</u> M.D. <u>Chestertown, Md.</u>		DATE SIGNED <u>11/12/56</u>	
PHYSICIAN'S NAME (Type) <u>Robert W. Farr</u> <u>Chestertown, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>II/14/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Chester Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Chestertown, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Willis Wells</u> ADDRESS <u>Chestertown, Md.</u>		24a. REC'D BY REGISTRAR <u>Nov. 14, 56</u>	24b. REGISTRAR'S SIGNATURE <u>Clara S. Barnes</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1956 NOV 16

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

UNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11445

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11438

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Kent b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 37 Chestertown c. LENGTH OF STAY IN life d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 100 Calvert St.		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Kent c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 37 Chestertown d. STREET ADDRESS Calvert St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle Murray Last Murray		4. DATE OF DEATH Month Nov. Day 24 Year 1956	
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 2, 1908
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY various	9. AGE (In years last birthday) 48 yrs.
11. BIRTHPLACE (State or foreign country) Kent. Co. Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Murray		14. MOTHER'S MAIDEN NAME Margaret Murray	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 216-05-6700	
17. INFORMANT Margaret Murray		Address Chestertown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Burns and probable carbon monoxide poisoning 916.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Deceased was found dead in a burning building in which he had been living.	
20c. TIME OF INJURY Month, Day, Year 11:00 a.m. Nov. 1956		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Chestertown Kent Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Robert W. Farr		DATE SIGNED Nov. 26, 1956	
EXAMINER'S NAME (Type) Robert W. Farr		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 28, 1956	22c. NAME OF CEMETERY OR CREMATORY Janes Cem.	22d. LOCATION (City, town, or county) (State) Chestertown, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Willis Wells		24a. REC'D BY REGISTRAR Nov. 27-56	
ADDRESS Chestertown, Md.		24b. REGISTRAR'S SIGNATURE Clara S. Barnes	

MISSOURI STATE DEPARTMENT OF HEALTH - BULLETIN 15
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH	
7. OCCUPATION		8. MARITAL STATUS		9. EDUCATION		10. RELIGION		11. SOCIAL CLASS		12. PRESENT ADDRESS	
13. DATE OF DEATH		14. TIME OF DEATH		15. PLACE OF DEATH		16. CAUSE OF DEATH		17. MANNER OF DEATH		18. SIGNATURE OF EXAMINER	
19. SIGNATURE OF WITNESS		20. SIGNATURE OF JURY		21. SIGNATURE OF CORONER		22. SIGNATURE OF MINISTER		23. SIGNATURE OF CHURCH		24. SIGNATURE OF FUNERAL HOME	
25. SIGNATURE OF BURIAL PLACE		26. SIGNATURE OF INTERMENT		27. SIGNATURE OF CEMETERY		28. SIGNATURE OF FUNERAL HOME		29. SIGNATURE OF BURIAL PLACE		30. SIGNATURE OF INTERMENT	

BUREAU V. 2

NOV 29 1956

RECEIVED

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 NOV 29 1956
 BUREAU V. 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11446 CERTIFICATE OF DEATH

11439

Reg. Dist. No. 202

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>		c. LENGTH OF STAY in 1b <u>4 weeks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kent & Queen Anne Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Chandley Fletcher Roberts</u>		4. DATE OF DEATH Nov. 8, 1956 Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>9/25/1909</u>
9. AGE (In years last birthday) <u>47</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>Kent Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Fletcher Roberts</u>		14. MOTHER'S MAIDEN NAME <u>Bulah Wilson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] [If yes, give war or dates of service] <u>no</u>		16. SOCIAL SECURITY NO. <u>184-07-5268</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular accident</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardio Vascular disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 DAY</u> <u>Years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>OCT 12</u> , 1956, to <u>NOV 8</u> , 1956, that I last saw the deceased alive on <u>NOV 8</u> , 1956, and that death occurred at <u>10 P. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Thomas J. Solon</u> M.D. <u>Chestertown</u> <u>11/8/56</u> PHYSICIAN'S NAME (Type) <u>Thomas J. Solon Chestertown, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/11/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Coleman's Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Coleman's Corner, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Willis Wells</u>		24a. REC'D BY REGISTRAR <u>NOV. 10-56</u>	
ADDRESS <u>Chestertown, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Clara S. Barnes</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION		6. PLACE OF BIRTH		7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN		13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF DECEASED	
JAMES H. HARRIS		Male		45		White		Farmer		Maryland		October 10, 1956		10:30 AM		Home		Heart Disease		Natural		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
16. PLACE OF INTERMENT		17. NAME OF INTERMENT		18. DATE OF INTERMENT		19. NAME OF MINISTER		20. NAME OF CHURCH		21. NAME OF FUNERAL HOME		22. NAME OF CEMETERY		23. NAME OF BURIAL		24. NAME OF CREMATION		25. NAME OF URN		26. NAME OF CASK		27. NAME OF COFFIN		28. NAME OF CASK		29. NAME OF COFFIN		30. NAME OF CASK	
St. John's Episcopal Church		St. John's Episcopal Church		October 10, 1956		Rev. J. H. Harris		St. John's Episcopal Church		J. H. Harris		St. John's Episcopal Church		St. John's Episcopal Church		St. John's Episcopal Church		St. John's Episcopal Church		St. John's Episcopal Church		St. John's Episcopal Church		St. John's Episcopal Church		St. John's Episcopal Church		St. John's Episcopal Church	

BUREAU V. S.

NOV 13 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 12 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11447 CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH a. COUNTY KENT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY QUEEN ANNE'S			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHESTERTOWN				c. LENGTH OF STAY IN 1b 1 day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION KENT + QUEEN ANNE'S HOSP				d. STREET ADDRESS MILLINGTON			
3. NAME OF DECEASED (Type or print) First MATTIE Middle ISABELLE Last ROCHESTER				4. DATE OF DEATH Month Nov Day 9 Year 1956			
5. SEX F		6. COLOR OR RACE COL		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAY 22, 1919	
9. AGE (In years last birthday) 37 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME William H. Elliott				12. CITIZEN OF WHAT COUNTRY? USA.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 213-228033		17. INFORMANT Hose. Chas. T.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) POST-OPERATIVE RESPIRATORY DEPRESSION 584X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ANESTHESIA FOR CHOLECYSTECTOMY DUE TO (c) CHRONIC CHOLECYSTITIS + CHOLELITHIASIS				INTERVAL BETWEEN ONSET AND DEATH 4 hrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from NOV 8, 1956 , to NOV 9, 1956 , that I last saw the deceased alive on NOV 9, 1956 , and that death occurred at 4 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Chas. T. Lee				ADDRESS (Street, city or town, state) CHESTERTOWN, Md.			
DATE SIGNED 11-9-56							
PHYSICIAN'S NAME (Type) A. T. KEEFE, JR. M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 13, 1956		22c. NAME OF CEMETERY OR CREMATORY Rich Neck Cem.		22d. LOCATION (City, town, or county) (State) Nr. Church Hill Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wells Wells				ADDRESS Chest ertown, Md.		24a. REC'D BY REGISTRAR Nov. 13-56	
				24b. REGISTRAR'S SIGNATURE Clara S. Barnes			

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		DATE OF DEATH		PLACE OF DEATH	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS	
PREVIOUS ILLNESS		TREATMENT		HISTORY		FAMILY HISTORY		SOCIAL HISTORY		HABITS		DIET		EXERCISE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR		SIGNATURE OF JUDGE		SIGNATURE OF SHERIFF	

BUREAU V. E.

NOV 15 1956

RECEIVED

11448 CERTIFICATE OF DEATH

Reg. Dist. No. 11441021

1. PLACE OF DEATH o. COUNTY <u>KENT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>37 CHESTERTOWN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Church Hill</u>	
c. LENGTH OF STAY in 1b <u>1 day</u>		d. STREET ADDRESS <u>"</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kent + Queen Anne Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>RUTH</u> Last <u>ROSS</u>		4. DATE OF DEATH Month <u>NOVEMBER</u> Day <u>3</u> Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 2, 1956</u>
9. AGE (In years last birthday) <u>0</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>CHARLES FRANKLIN ROSS</u>		14. MOTHER'S MAIDEN NAME <u>ALICE ELIZABETH COLEMAN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>HOSPITAL RECORDS (Mother)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>759.3</u> DUE TO <u>congenital</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>abnormality of upper respiratory tract</u> DUE TO <u>Cleft palate;</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>6 hr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congenital heart lesion; spina bifida occulta</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 2, 1956</u> , to <u>Nov 3, 1956</u> , that I last saw the deceased alive on <u>Nov 3, 1956</u> , and that death occurred at <u>11:50 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Florence Deringer Joyce</u> M.D.		ADDRESS (Street, city or town, state) <u>Worton, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>Florence Deringer Joyce</u>		DATE SIGNED <u>Worton, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov. 4, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Chesler Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Chesler, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Marvin V. Williams - Chesler, Md.</u>		24a. REC'D BY REGISTRAR <u>Nov. 6 - 56</u>	24b. REGISTRAR'S SIGNATURE <u>Clara L. Barnes</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2072386XV4

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS	
JAMES EARL RAY		MALE		35		JAN 5 1928		MEMPHIS, TENN.		MEMBER OF CONGRESS		SHOOTING		SUICIDE		APR 4 1968		MEMPHIS, TENN.		JAMES EARL RAY		JAMES EARL RAY	
FATHER'S NAME		MOTHER'S NAME		EDUCATION		RELIGION		MARRIAGE		MILITARY SERVICE		PREVIOUS ILLNESS		ALCOHOL		DRUGS		TOBACCO		OTHER		REMARKS	
JAMES EARL RAY		JAMES EARL RAY		HIGH SCHOOL		METHODIST		MARRIED		ARMY		NONE		NONE		NONE		NONE		NONE		NONE	
DATE OF DEATH		PLACE OF DEATH		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		DATE OF DEATH		PLACE OF DEATH		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		DATE OF DEATH		PLACE OF DEATH		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS	
APR 4 1968		MEMPHIS, TENN.		JAMES EARL RAY		JAMES EARL RAY		APR 4 1968		MEMPHIS, TENN.		JAMES EARL RAY		JAMES EARL RAY		APR 4 1968		MEMPHIS, TENN.		JAMES EARL RAY		JAMES EARL RAY	

BUREAU V. 8

NOV 7 1956

RECEIVED

11449 CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH a. COUNTY <u>KENT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>KENT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESTERTOWN</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESTERTOWN</u>			
c. LENGTH OF STAY IN 1b <u>35 yrs</u>				d. STREET ADDRESS <u>RFD</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kent + Queen Anne's</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JEWELL KELLOGG SMITH</u>			4. DATE OF DEATH Month Day Year <u>Nov 11 1952</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 5, 1890</u>		9. AGE (In years last birthday) <u>66</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>owner</u>		11. BIRTHPLACE (State or foreign country) <u>NEW YORK</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>JOHN JEWELL SMITH</u>			14. MOTHER'S MAIDEN NAME <u>MARY PEASLEE</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>UNK</u> (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT Address <u>HOSPITAL RECORD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>570.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Post-operative State: Intestinal Obstruction.</u> DUE TO (b) <u>Intestinal Obstruction.</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Concussion.</u>					INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell down stairs.</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>9</u> p.m. <u>Nov 8 1952</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>			
				20f. (City or town) (County) (State) <u>Chestertown Kent Md</u>			
21. I certify that I attended the deceased from <u>Nov 8</u> , 19 <u>52</u> , to <u>Nov 11</u> , 19 <u>52</u> , that I last saw the deceased alive on <u>Nov 11</u> , 19 <u>52</u> , and that death occurred at <u>5 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>CHESTERTOWN, Md</u> DATE SIGNED <u>11-11-52</u>							
ACTUAL SIGNATURE <u>A.T. KEEFE, JR.</u> M.D.							
PHYSICIAN'S NAME (Type) <u>A.T. KEEFE, JR., M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 14, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Paul Cem.</u>			
				22d. LOCATION (City, town, or county) (State) <u>Nr. Chestertown, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Willis Wells</u>		ADDRESS <u>Chestertown, Md.</u>		24a. REC'D BY REGISTRAR <u>Nov. 14. 56</u>			
				24b. REGISTRAR'S SIGNATURE <u>Clara S. Barnes</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Place of birth		6. Date of death		7. Place of death		8. Cause of death		9. Manner of death		10. Signature of physician		11. Signature of registrar		12. Signature of informant	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If on duty, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 11443
11455 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 14 FilmG207 12-3-56 et

Reg. Dist. No. 200

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Galtr</u>		c. LENGTH OF STAY IN lb <u>2 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Galtr -</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Dorothy</u> Middle <u>Clara</u> Last <u>Sommers</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>18</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 14, 1913</u>	
9. AGE (In years last birthday) <u>43</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Quillen</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Willbert Sommers</u> Address <u>Galtr, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brain Tumor (postoperative)</u> DUE TO <u>237X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Operated in Delaware Jail Hosp. Wilmington Md in Aug. 1956 for 6 wks. Hospitalized 8 weeks. Home about 4 weeks - found dead in bed about 6 am. To day</u> DUE TO <u>Aug. 1956 for 6 wks. Hospitalized 8 weeks. Home about 4 weeks - found dead in bed about 6 am. To day</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Robert W. Farr</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>ROBERT W. FARR</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 20 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Millington Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Millington Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Yellow Millington Md.</u>				24b. REC'D BY REGISTRAR <u>NOV 26 1956</u>		24a. REGISTRAR'S SIGNATURE <u>Hy. Mulford</u>	

NOV 26 1956

RECEIVED

11450 CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Kent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kent & Green Anns</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>CLIFTON</u> First <u>E</u> Middle <u>WESLEY</u> Last		4. DATE OF DEATH Month <u>11</u> Day <u>1</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 25, 1913</u>
9. AGE (In years last birthday) <u>42</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cyber Shucker</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Wesley</u>		14. MOTHER'S MAIDEN NAME <u>Carrie Brooks</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Emma Wesley - Rock Hall</u>		Address <u>Rock Hall records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septic Meningitis</u> <u>340.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>10/31</u> , 19 <u>56</u> , to <u>11/1</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11/1/56</u> , 19 <u>56</u> , and that death occurred at <u>10:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert W. Farr</u> M.D.		ADDRESS (Street, city or town, state) <u>Chestertown, Md</u> DATE SIGNED <u>11/1/56</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT W. FARR</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/5/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Sharptown Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Rock Hall, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Willis Wells</u> ADDRESS <u>Chestertown, Md.</u>		24a. REC'D BY REGISTRAR <u>Nov. 5-56</u>	24b. REGISTRAR'S SIGNATURE <u>Clara S. Barnes</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>DATE OF DEATH: <u>10/10/56</u></p>		<p>PLACE OF DEATH: <u>Home</u></p>	
<p>DECEASED'S NAME: <u>John Doe</u></p>		<p>AGE: <u>45</u></p>	
<p>SEX: <u>Male</u></p>		<p>RACE: <u>White</u></p>	
<p>DATE OF BIRTH: <u>10/10/11</u></p>		<p>PLACE OF BIRTH: <u>MD</u></p>	
<p>CAUSE OF DEATH: <u>Heart Disease</u></p>		<p>IMMEDIATE CAUSE: <u>Myocardial Infarction</u></p>	
<p>DATE OF EXAMINATION: <u>10/10/56</u></p>		<p>PLACE OF EXAMINATION: <u>Home</u></p>	
<p>DATE OF REPORT: <u>10/10/56</u></p>		<p>PLACE OF REPORT: <u>Home</u></p>	
<p>REPORTED BY: <u>John Doe</u></p>		<p>REPORTED BY: <u>John Doe</u></p>	
<p>DATE OF DEATH: <u>10/10/56</u></p>		<p>PLACE OF DEATH: <u>Home</u></p>	
<p>DECEASED'S NAME: <u>John Doe</u></p>		<p>AGE: <u>45</u></p>	
<p>SEX: <u>Male</u></p>		<p>RACE: <u>White</u></p>	
<p>DATE OF BIRTH: <u>10/10/11</u></p>		<p>PLACE OF BIRTH: <u>MD</u></p>	
<p>CAUSE OF DEATH: <u>Heart Disease</u></p>		<p>IMMEDIATE CAUSE: <u>Myocardial Infarction</u></p>	
<p>DATE OF EXAMINATION: <u>10/10/56</u></p>		<p>PLACE OF EXAMINATION: <u>Home</u></p>	
<p>DATE OF REPORT: <u>10/10/56</u></p>		<p>PLACE OF REPORT: <u>Home</u></p>	
<p>REPORTED BY: <u>John Doe</u></p>		<p>REPORTED BY: <u>John Doe</u></p>	

BUREAU V. 31

NOV 7 1956

RECEIVED